

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008334

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2647

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF  
MEDICAL CERTIFICATION

KHATOON  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

FILED MAR 14 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS MO.</b>		c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. # 1</b>		d. STREET ADDRESS (If outside, give location) <b>4276 WASHINGTON</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED <b>BEVERLY</b> first Middle Last <b>BIRCHFIELD</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>23</b> Year <b>1963</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/22/63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>	
13a. FATHER'S NAME <b>WALTER F. BIRCHFIELD</b>		13b. MOTHER'S MAIDEN NAME <b>RUTH WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		17. INFORMANT <b>ST. LOUIS CITY HOSP. #1.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEONATAL DEATH</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ATELECTASIS</b> DUE TO (c) <b>762.0</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>5:30</b> a.m. p.m. Month, Day, Year <b>2/22/63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>2/22/63</b>		20f. CITY, TOWN, OR LOCATION <b>2/23/63</b> COUNTY <b>2/23/63</b> STATE	
21. I attended the deceased from <b>5:30 a.m.</b> to <b>2/23/63</b> and last saw her alive on <b>2/23/63</b> Death occurred at <b>5:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.O.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>2/23/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-30-63</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Rowland Mortuary Svc.</b> ADDRESS <b>4104-06 Manchester</b>		25. DATE REC'D. BY LOCAL REG. <b>MAR 7 1963</b>	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.